

7873

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun, R.D.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rising Sun R.D.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry E Abrams		4. DATE OF DEATH Month Day Year 7 5 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-1861
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Abrams		14. MOTHER'S MAIDEN NAME Lucy J. Agen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. -- -- -- -- --	
17. INFORMANT Norris Abrams, North East, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangreen of left lower leg 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Arteriosclerosis general DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. Dodson		DATE SIGNED 7-6-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-8-58	
22c. NAME OF CEMETERY OR CREMATORY Ebenzer		22d. LOCATION (City, town, or county) (State) NORTH EAST R.D. Cecil Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph A. Grant North East Md		24a. REC'D BY REGISTRAR DATE JUL 9 '58	
24b. REGISTRAR'S SIGNATURE All. Leach			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1933

ALABAMA

DATE OF DEATH
PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07857

Reg. Dist. No.

7874

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Chester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, R.D.		c. LENGTH OF STAY IN 1b Passing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale Rural		75 x 13	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cecil Middle Sidney Last Allen				4. DATE OF DEATH Month 7 Day 12 Year 19 58			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-35		9. AGE (In years last birthday) 23 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Paper Mill		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Ted Allen				14. MOTHER'S MAIDEN NAME Loatha Winebarger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 237-54-3926		17. INFORMANT Ted Allen Avondale R.D. 1. Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractures of base of skull, neck and lower jaw. 816x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) lacerated right forearm and contused eyes DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) His car was hit by truck					
20c. TIME OF INJURY Month, Day, Year 7 12 58 a. m. 4:5 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) North East (County) Cecil (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-13-58		22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) West Jefferson Ash (State) M.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph A. Grant North East Md				24a. REC'D BY REGISTRAR DATE JUL 15 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOTARY
PUBLIC

County

City

Residence

Usual

Avondale Rural

Residence

North East, P. O.

x

23

IN

Y

23

Allen

Edwin

Usual

2-11-32

23

U.S.A.

North Carolina

Edwin Allen

Edwin Allen

Leola Winters

Ed Allen

2-11-32

2-11-32

no

Indication of cause of death, with the manner in which it was caused, and the date of death.

1

It was caused by

7-12-32

12

Usual

North East

North East

x

IN

Y

x

7-12-32

x

7-12-32

7-12-32

U.S.A.

North Carolina

North Carolina

7-12-32

7-12-32

CERTIFICATE OF DEATH

Reg. Dist. No.

07858

7875

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. LENGTH OF STAY IN 1b 23 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milford		d. STREET ADDRESS 412 Charles Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PHILIP Middle A. Last ANDOLORA		4. DATE OF DEATH Month 7 Day 4 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-25
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Leroy, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Andolora		14. MOTHER'S MAIDEN NAME Lina Messana	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 086-18-3164	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage subarachnoid and into right ventricle DUE TO following surgery Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Aneurysm, congenital, vessels of fourth ventricle DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 36 hrs Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-12 , 19 58 , to 7-4-58 , 19 58 . that I attended the deceased lived on XXXXXXXXXXXXXXXXXXXX , and that death occurred at 8:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA Hospital, Perry Point, Md. 7-4-58			
ACTUAL SIGNATURE Elizabeth Ellis		M.D. VA Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) ELIZABETH ELLIS, M.D. Acting Director Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-4-58	
22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Leroy, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington		ADDRESS Havre De Grace, Md.	
24a. REC'D BY REGISTRAR 8 '58		24b. REGISTRAR'S SIGNATURE DeLoach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07859

CERTIFICATE OF DEATH

Reg. Dist. No.

7858

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 143 E. High St.				d. STREET ADDRESS 143 E. High ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Carrie		Middle A.		Last Atkinson		4. DATE OF DEATH Month July Day 7 Year 1958	
5. SEX F	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-1886		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John A. Morgan				14. MOTHER'S MAIDEN NAME Annie Ash			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Alice Anna Everett		Address 143 E. High St. Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Hypertensive arteriosclerotic cardio-vascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2, 1958, to July 7, 1958, that I last saw the deceased alive on July 8, 1958, and that death occurred at 12:15 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED S. RALPH A NDREWS, JR., M.D. 233 E. Main St. 7/8/58 Elkton, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7-10-1958		22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memo. Pk.		22d. LOCATION (City, town, or county) (State) R. D. Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pippin Funeral Home 143 E. High St. Elkton, Md.				24a. REC'D BY REGISTRAR DATE JUL 14 '58		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 15, 1918	
AGE		SEX	
65		Male	
RACE		COLOR	
White		White	
BIRTH DATE		BIRTH PLACE	
JANUARY 1, 1853		Maryland	
MARRIAGE DATE		MARRIAGE PLACE	
JANUARY 1, 1875		Maryland	
EDUCATION		OCCUPATION	
High School		Farmer	
RELIGION		CAUSE OF DEATH	
Roman Catholic		Heart Disease	
PREVIOUS ILLNESS		MANNER OF DEATH	
None		Natural	
PLACE OF DEATH		RESIDENCE	
Home		123 Main St., Baltimore, Md.	
DATE OF INTERMENT		PLACE OF INTERMENT	
JANUARY 18, 1918		St. Mary's Cemetery	
NAME OF MINISTER		NAME OF CLERGYMAN	
John J. Smith		John J. Smith	
NAME OF FUNERAL HOME		NAME OF BURIAL PLACE	
None		St. Mary's Cemetery	
NAME OF CERTIFYING PHYSICIAN		NAME OF REGISTRAR	
Dr. J. H. Jones		John J. Smith	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7876 CERTIFICATE OF DEATH

Reg. Dist. No. 07860

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL EARLEVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL EARLEVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>BENJAMIN F. BAILEY</u>				4. DATE OF DEATH Month Day Year <u>JULY 7 1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 21 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>RETIRED FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>			
13. FATHER'S NAME <u>JAMES BAILEY</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN HUSFELT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-20-7949</u>			
17. INFORMANT <u>TEMPERANCE BAILEY, EARLEVILLE MD.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>years</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 24</u> , 19 <u>58</u> , to <u>7 July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7 July</u> , 19 <u>58</u> , and that death occurred at <u>6:28</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace O'Brien</u>				ADDRESS (Street, city or town, state) <u>M.D. Cecilton, Md.</u>			
DATE SIGNED <u>9 July 58</u>							
PHYSICIAN'S NAME (Type) <u>WALLACE OBENSHAIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7/10/58</u>		<u>CECILTON CEM.</u>		<u>CECILTON, CECIL, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Bellows, Millington Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Quesada</u>	

7877 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY York			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecil				c. LENGTH OF STAY IN IB 1 month 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle E. Last BARNETT				4. DATE OF DEATH Month July Day 19 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-6-98	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 60 Hours 60 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger (retired)		11. BIRTHPLACE (State or foreign country) Cardiff, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harold A. Barnett		14. MOTHER'S MAIDEN NAME Lucy Mae Reynolds		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) Yes (If yes, give war or dates of service) WWI	
16. SOCIAL SECURITY NO. 179-09-6539		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis due to extravasation of contents of viscera. DUE TO 540.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Peptic Ulcer, Bleeding. DUE TO Unknown (c) Gastrojejunostomy (7-11-58)		INTERVAL BETWEEN ONSET AND DEATH 4 - 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema Pulmonary, bilateral, severe, unknown cause.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. VA		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-26 , 19 58 , to 7-19 , 19 58 , that I saw the deceased live on 7-19 , 19 58 , and that death occurred at 8:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Burke Suitt				ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md.		DATE SIGNED 7-20-58	
PHYSICIAN'S NAME (Type) R. BURKE SUITT, M.D., Acting Director, Professional Services.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-23-58		22c. NAME OF CEMETERY OR CREMATORY Mount Nebo		22d. LOCATION (City, town, or county) (State) Delta, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins HARKINS FUNERAL HOME, Delta, Pa.				24a. REC'D BY REGISTRAR JUL 22 '58		24b. REGISTRAR'S SIGNATURE W. H. Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1927

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7878 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07862

Reg. Dist. No. 96

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 10yrs. 5mo. 3days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 4402 Marx Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle A. Last BARTHA				4. DATE OF DEATH Month July Day 25 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-29-20		9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Iron Worker		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John Bartha				14. MOTHER'S MAIDEN NAME Emma (?)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Second third degree burns over entire body 979x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 9 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Poured gasoline on himself and set fire to it.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 2:30 7-16 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 403 N. Collington St. Baltimore, Maryland		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>R. C. Dodson</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. DODSON				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 27, 1958		22c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL PRK		22d. LOCATION (City, town, or county) (State) PARKVILLE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Burn Louis Larson 4, Md.</i>				24a. REC'D BY REGISTRAR DATE JUL 28 '58		24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>	

1898

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
STATE OF NEW YORK

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Education		Previous Illness		Cause of Death		Place of Death		Time of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
John Doe		35		Male		Caucasian		White		Roman Catholic		Single		Teacher		High School		None		Heart Disease		Home		July 25, 1908		J. D. Smith		J. E. Jones		J. F. Brown	
Date of Birth		Date of Death		Time of Death		Place of Death		Cause of Death		Previous Illness		Marital Status		Occupation		Education		Previous Illness		Cause of Death		Place of Death		Time of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Jan 1, 1873		July 25, 1908		10:00 AM		Home		Heart Disease		None		Single		Teacher		High School		None		Heart Disease		Home		July 25, 1908		J. D. Smith		J. E. Jones		J. F. Brown	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7859

CERTIFICATE OF DEATH

07863

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last J. Frank Blake Jr.				4. DATE OF DEATH Month Day Year July 30 1958			
5. SEX White M.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 12 1902	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conowingo Power Co. Manager		10b. KIND OF BUSINESS OR INDUSTRY Childs	
11. BIRTHPLACE (State or foreign country) Childs Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME J. Frank Blake Sr.				14. MOTHER'S MAIDEN NAME Florence A. Burke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-05-3956		17. INFORMANT Mrs. J. Frank Blake Childs Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Carcinomatosis and cachexia 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2. Carcinoma of the large bowel DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 months 3 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3. Severe bilateral sciatic neuritis secondary to 2.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 16, 1957, to July 30, 1958, that I last saw the deceased alive on July 30, 1958, and that death occurred at 9 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr.				ADDRESS (Street, city or town, state) DATE SIGNED 233 E. Main Street 7/31/58			
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 2 1958		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Donald R. The ELKTON, MD				24a. REC'D BY REGISTRAR DATE AUG 5 '58		24b. REGISTRAR'S SIGNATURE	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07864

7879 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CECIL</u>		STATE <u>Md</u> COUNTY <u>CECIL</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN		TOWN	
TOWN <u>NORTH EAST</u>		<u>Lifetime</u>		<u>NORTH EAST</u>		<u>RURAL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
1				-			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>GRACE</u> (Middle) <u>PHILLIPS</u> (Last) <u>BOULDEN</u>				<u>7</u> <u>26</u> <u>1958</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>2-5-1888</u>	<u>70</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>		<u>-</u>		<u>MARYLAND</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WILLIAM D. PHILLIPS</u>				<u>MARY DEMOND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>-</u>		<u>Mrs Boulden North East Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)				<u>Coronary Occlusion</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Generalized Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>3 yrs.</u>			
STATING UNDERLYING CAUSE LAST, DUE TO (C)				<u>3 yrs.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Diabetes Mellitus ; Pleurisy - left lower lung</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
<u>260X -</u>		<u>-</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<u>3 hrs.</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>24 July, 1958</u>		<u>26 July, 1958</u>		<u>26 July, 1958</u>			
22. I hereby certify that I attended the deceased from <u>24 July, 1958</u>, to <u>26 July, 1958</u>, that I last saw the deceased alive on <u>25 July, 1958</u>, and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Blans H. Humber</u>				DATE SIGNED <u>26 July '58</u>			
M.D. <u>North East Md</u>				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7-29-58</u>		<u>METHO DIST</u>		<u>NORTH EAST CECIL Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>JUL 30 '58</u>		<u>W. H. Humber</u>		<u>Joseph R. Humber North East Md</u>			
DATE							

CERTIFICATE OF DEATH

Reg. No. 42

1. NAME OF DECEASED

2. SEX

3. DATE OF BIRTH
4. PLACE OF BIRTH
5. OCCUPATION

6. MARRIAGE

7. DATE OF DEATH
8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MEDICAL HISTORY

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED

19. SIGNATURE OF DECEASED

20. SIGNATURE OF DECEASED

21. SIGNATURE OF DECEASED

22. SIGNATURE OF DECEASED

23. SIGNATURE OF DECEASED

24. SIGNATURE OF DECEASED

25. SIGNATURE OF DECEASED

26. SIGNATURE OF DECEASED

27. SIGNATURE OF DECEASED

28. SIGNATURE OF DECEASED

29. SIGNATURE OF DECEASED

30. SIGNATURE OF DECEASED

31. SIGNATURE OF DECEASED

32. SIGNATURE OF DECEASED

33. SIGNATURE OF DECEASED

34. SIGNATURE OF DECEASED

35. SIGNATURE OF DECEASED

36. SIGNATURE OF DECEASED

37. SIGNATURE OF DECEASED

38. SIGNATURE OF DECEASED

39. SIGNATURE OF DECEASED

40. SIGNATURE OF DECEASED

41. SIGNATURE OF DECEASED

42. SIGNATURE OF DECEASED

43. SIGNATURE OF DECEASED

44. SIGNATURE OF DECEASED

NOTARY PUBLIC

STATE OF MARYLAND

7880 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradshaw 12x-2	
c. LENGTH OF STAY IN b 10yrs.8mo.13 days		d. STREET ADDRESS RFD 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARMFIELD Middle S. Last BROWN		4. DATE OF DEATH Month July Day 31 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-05
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min. 53	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shell Inspector		10b. KIND OF BUSINESS OR INDUSTRY Army Chemical Center Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Brown - Deceased		14. MOTHER'S MAIDEN NAME Phoebe Pinkney - Deceased	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis, generalized, severe DUE TO (c) unknown INTERVAL BETWEEN ONSET AND DEATH 3-4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 18, 19 47, to July 31, 19 58 , and that death occurred at 12:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 7-31-58			
ACTUAL SIGNATURE S. P. LACERVA		PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/4/58	
22c. NAME OF CEMETERY OR CREMATORY Asbury Methodist Church		22d. LOCATION (City, town, or county) (State) Loreley, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE AUG 6 '58		24b. REGISTRAR'S SIGNATURE W. L. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 50 1 2 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 50 1 2 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7881 CERTIFICATE OF DEATH

07866
Reg. Dist. No. 98

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 12yrs. 1mo. 22days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne				198-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> unknown							
3. NAME OF DECEASED (Type or print) First MIDDLE Last DAVID M. CATON				4. DATE OF DEATH Month Day Year July 7 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6-17-94	
9. AGE (In years lost birthday) yrs. 64		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Self-employed			
11. BIRTHPLACE (State or foreign country) Fulton County, Indiana				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Caton - Deceased				14. MOTHER'S MAIDEN NAME Lois Marah - Deceased			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 218-20-3913			
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and congestion, bilateral 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema, bilateral, severe DUE TO Rheumatic heart disease inactive, with calcification of the aortic valve (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) unknown							INTERVAL BETWEEN ONSET AND DEATH 2-3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 15 1946, to July 7 1958, that I last saw the deceased alive on July 7 1958, and that death occurred at 7:10 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE W. M. HARRIS				ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 7-9-58			
PHYSICIAN'S NAME (Type) W. M. HARRIS				Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7/10/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE P. Pennington & Son				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE JUL 15 '58	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7860

CERTIFICATE OF DEATH

Reg. Dist. No. 07867

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elk Mills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Kay Cooke</u>				4. DATE OF DEATH Month Day Year <u>July 6 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9, 1898</u>	
9. AGE (In years last birthday) yrs. <u>59</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper-Furniture</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>R. John Kay</u>				14. MOTHER'S MAIDEN NAME <u>Annie S. Atkinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-0214</u>		17. INFORMANT Address <u>Arnold C. Cooke, Elk Mills, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>Diabetes Mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>June 28, 1958</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 29, 1958</u> to <u>July 6, 1958</u> that I last saw the deceased alive on <u>July 6, 1958</u> , and that death occurred at <u>10:21</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Elkton, Md.</u> DATE SIGNED <u>July 9-1958</u>							
ACTUAL SIGNATURE <u>Milford H. Sprecher</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Milford H. Sprecher</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 9, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cherry Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 14 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Search</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07868

7882

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 1 month 16 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last CLAUDE (NMI) CURRY				4. DATE OF DEATH Month Day Year July 13 19 58					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-15-92			
9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Evergreen, Florida.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Walter Curry				14. MOTHER'S MAIDEN NAME Charlotte Knowland					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI				16. SOCIAL SECURITY NO. 578-24-6878		17. INFORMANT Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved. DUE TO (b) Plasma cell myeloma. DUE TO (c) Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, mod. severe.								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) VA				(County)		(State)			
21. I certify that I attended the deceased from 5-28-58 , to 7-13-58 , and that death occurred at 5:37 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA Hospital, Perry Point, Md. 7-14-58									
ACTUAL SIGNATURE W. M. HARRIS				PHYSICIAN'S NAME (Type) W. M. HARRIS Acting Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/16/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE PHINNINGTON & SON				ADDRESS Harrods de Grace, Md.		24a. REC'D BY REGISTRAR DATE JUL 25 '58			
24b. REGISTRAR'S SIGNATURE W. H. Leach									

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07869

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EARLEVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle G. Last DIXON		4. DATE OF DEATH Month JULY Day 18 Year 1958	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 29, 1888
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK GONCE		14. MOTHER'S MAIDEN NAME ANNA WILSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MARION DIXON, R.D.		Address CHESTERTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cellulitis of the legs with massive edema.			INTERVAL BETWEEN ONSET AND DEATH weeks years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 July , 19 58 , to 18 July , 19 58 , that I last saw the deceased alive on 18 July , 19 58 , and that death occurred at 5 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Minkam M.D.		ADDRESS (Street, city or town, state) Cecilton, Md.	
DATE SIGNED 18 July 58			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	7/20/58	GALENA CEM.	GALENA, Kent Co., MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Sellers, Millington, Md.		24a. REC'D BY REGISTRAR JUL 22 58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Q. L. Smith	

CERTIFICATE OF DEATH

NAME OF DECEASED Frank Frank Wilson		SEX Male		DATE OF BIRTH Jan 15 1885		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Single		OCCUPATION Clerk		RESIDENCE 1234 N. E. St. Baltimore, Md.		PLACE OF DEATH Home	
DATE OF DEATH Dec 10 1915		TIME OF DEATH 10:30 A.M.		PLACE OF DEATH Home		CAUSE OF DEATH Myocardial infarction	
MEDICAL HISTORY None		SURGICAL HISTORY None		PRESENT ILLNESS Sudden		POST MORTEM None	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF DECEASED Frank Frank Wilson		SIGNATURE OF WITNESS J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith	

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the coroner or other person who has examined the body, or by the registrar of the health department. It is to be filled out in duplicate, one copy to be retained by the registrar, and the other copy to be sent to the health department.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7862

CERTIFICATE OF DEATH

Reg. Dist. No. 07870

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BLANCHE</u> Middle <u>V.</u> Last <u>GOVER</u>		4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>18</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Harford County, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eli Fleming</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Bond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Rev. H. Gover</u>		Address <u>North East</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent right cerebral thrombosis</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Renal Disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>21 July</u> , 19 <u>58</u> , to <u>24 July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>23 July</u> , 19 <u>58</u> , and that death occurred at <u>2 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Klaus H. Huchner</u>		ADDRESS (Street, city or town, state) <u>No. 14 E. 1 St</u> DATE SIGNED <u>24 July '58</u>	
PHYSICIAN'S NAME (Type) <u>Klaus H. Huchner M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>7/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Leon K. Proctor Funeral Home</u>	22d. LOCATION (City, town, or county) (State) <u>Cockeysville Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullock</u>		24a. REC'D BY REGISTRAR <u></u> DATE <u>JUL 28 '58</u>	24b. REGISTRAR'S SIGNATURE <u></u>

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John A. Jones</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Dec 15 1918</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Engineer</i>		RELIGION <i>Methodist</i>	
EDUCATION <i>High School</i>		MARRIAGE <i>Married</i>		SPOUSE <i>John A. Jones</i>		CHILDREN <i>3</i>	
BIRTH <i>Dec 15 1873</i>		PLACE OF BIRTH <i>Harford</i>		FATHER <i>John A. Jones</i>		MOTHER <i>John A. Jones</i>	
PREVIOUS ILLNESS <i>Heart Disease</i>		TREATMENT <i>Medical</i>		PHYSICIAN <i>John A. Jones</i>		HOSPITAL <i>John A. Jones</i>	
DATE OF BURIAL <i>Dec 18 1918</i>		PLACE OF BURIAL <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
SIGNATURE OF DECEASED <i>John A. Jones</i>		SIGNATURE OF WITNESS <i>John A. Jones</i>		SIGNATURE OF PHYSICIAN <i>John A. Jones</i>		SIGNATURE OF CLERK <i>John A. Jones</i>	
DATE <i>Dec 18 1918</i>		PLACE <i>Harford</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7883 CERTIFICATE OF DEATH

07871

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point, Md.</u>				c. LENGTH OF STAY IN 1b <u>1 month 17 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>3301 English Consul Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>GEORGE</u> Last <u>GRIFFITHS</u>				4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Percival L. Griffiths</u>				14. MOTHER'S MAIDEN NAME <u>Louellen Evans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-I</u>				16. SOCIAL SECURITY NO. <u>705 09 6710</u>		17. INFORMANT Address <u>Hospital Records, VA Hosp., Perry Point, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of branch of left middle cerebral artery.</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic cerebral vascular disease</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus.</u> 260X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>VA</u> attended the deceased from <u>May 16, 19 58</u> , to <u>July 3, 19 58</u> , and that death occurred at <u>6:53 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>E. S. ELLS</u> , M.D. <u>V.A. Hospital, Perry Point, Md.</u>				DATE SIGNED <u>7-4-58</u>			
PHYSICIAN'S NAME (Type) <u>E. S. ELLS, M.D.,</u> Acting Director, Professional Services.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-7-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL BALTO</u>		22d. LOCATION (City, town, or county) (State) <u>MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight, Inc.</u> ADDRESS <u>6009 Hartford Rd., Baltimore, Md.</u>				24a. REC'D BY REGISTRAR <u>JUL 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07872

7863 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 21		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 113 Booth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle J. Last Harris		4. DATE OF DEATH Month July Day 3 Year 19 58					
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1936		9. AGE (In years last birthday) 21 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10b. KIND OF BUSINESS OR INDUSTRY Jobbing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Alfred Harris				14. MOTHER'S MAIDEN NAME Irene Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-32-7279		17. INFORMANT, Address Irene Harris-113 Booth Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Libido come DUE TO (b) Libido mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 7:20, 1958, to 7:30, 1958, that I last saw the deceased alive on 7:30, 1958, and that death occurred at 3:40 M, from the causes and on the date stated above. ACTUAL SIGNATURE Peter Shuck M.D. ADDRESS (Street, city or town, state) 154 W Main DATE SIGNED 7-3-58 PHYSICIAN'S NAME (Type) PETER STAVRAKIS M.D. Elkton Md 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 8/6/58 22c. NAME OF CEMETERY OR CREMATORY Providence Cem. 22d. LOCATION (City, town, or county) (State) Elkton, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE Address C. W. P. Bell Wilm. Del. 24a. REC'D BY REGISTRAR DATE JUL 7 1958 24b. REGISTRAR'S SIGNATURE							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7884 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07873

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Del. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fredericktown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smyrna 46X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 23 N. Main St.	
3. NAME OF DECEASED (Type or print) First John Middle D. Last Johnson		4. DATE OF DEATH Month 7 Day 26 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-1906
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Appliance Dealer		12. KIND OF BUSINESS OR INDUSTRY House hold appliance Philadelphia	
13. BIRTHPLACE (State or foreign country) U.S.A.		14. CITIZEN OF WHAT COUNTRY	
15. FATHER'S NAME A. Johnson		16. MOTHER'S MAIDEN NAME Ann Hagotian	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		18. SOCIAL SECURITY NO.	
19. INFORMANT Albert D. Johnson, Church Rd. Bridge Port Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 850X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off boat in 16 feet of water	
20c. TIME OF INJURY Month, Day, Year 5-25 7 26 19 58		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> River	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fredericktown Cecil Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-28-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-30-58	
22c. NAME OF CEMETERY OR CREMATORY W. Laurel Com.		22d. LOCATION (City, town, or county) (State) Philadelphia Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Lister Daniels Middletown		24a. REC'D BY REGISTRAR DATE AUG 4 '58	
24b. REGISTRAR'S SIGNATURE W. J. Smith		24c. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
1921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
DEPT.

NAME OF DECEASED		John	
RESIDENCE		Fredericktown	
DATE OF DEATH		12-17-1920	
PLACE OF DEATH		Home	
CAUSE OF DEATH		Heart failure	
MANNER OF DEATH		Natural	
AGE		65	
SEX		Male	
RACE		White	
RELIGION		Roman Catholic	
EDUCATION		High School	
OCCUPATION		Farmer	
MARRIED		Yes	
SINGLE		No	
WIDOWED		No	
DIVORCED		No	
MILITARY SERVICE		None	
PREVIOUS ILLNESS		None	
TREATMENT		None	
BURIAL		Yes	
CITY		Fredericktown	
COUNTY		St. Mary's	
STATE		Maryland	
SIGNATURE OF EXAMINER		J. H. Johnson	
TITLE		Medical Examiner	
DATE		12-17-1920	
PLACE		Fredericktown	
COUNTY		St. Mary's	
STATE		Maryland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

7885

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07874

Items 13 & 14 Film G231

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle	
c. LENGTH OF STAY IN 1b 6yrs2mos4days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 433 S. Union St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BENEDICT J. KAUSS		4. DATE OF DEATH Month Day Year 7 3 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-86
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Fred Kauss		14. MOTHER'S MAIDEN NAME Unknown Katherine Hoelle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 20 minutes			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 29, 19 32 , to July 3, 19 58 , that I last saw the deceased alive on July 3, 19 58 , and that death occurred on July 3, 19 58 , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V. A. Hospital, Perry Point, Md. DATE SIGNED _____ ACTUAL SIGNATURE S. P. Lacerva M.D. V. A. Hospital, Perry Point, Md. PHYSICIAN'S NAME (Type) S. P. LACERVA, M.D. Director Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) 7/2/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Cathedral		22d. LOCATION (City, town, or county) (State) Wilmington Del.	
23. FUNERAL DIRECTOR'S SIGNATURE PERKINSON & SONS, Harry De Grace, Md.		24a. REC'D BY REGISTRAR JUL 8 '58	
24b. REGISTRAR'S SIGNATURE Archer			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7886 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07875

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit R.D.		c. LENGTH OF STAY IN 1b 11 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit R.D.	
3. NAME OF DECEASED (Type or print) MACK First KEEN Middle KEEN Last		4. DATE OF DEATH 7-12-1958 Month 7- Day 12 Year 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-1871
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Floyd Keen		14. MOTHER'S MAIDEN NAME Susie Keen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 236-26-1621	
17. INFORMANT Shirley Dickerson, Port Deposit, Md. R.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary and Cerebral Accident. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Alfred Dodson M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-16-58	
22c. NAME OF CEMETERY OR CREMATORY Belair Mem. Gardens		22d. LOCATION (City, town, or county) (State) Belair Harford Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Vermon E. McMiller ADDRESS Esingden Md.		24a. REC'D BY REGISTRAR JUL 15 '58 DATE	
24b. REGISTRAR'S SIGNATURE Alfred Dodson			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7887 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07877

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.		c. LENGTH OF STAY IN 1b 34 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Elkton, R.D.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Mary Klukewicz			4. DATE OF DEATH Month Day Year 7 10 19 58		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-1-1889		9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Triump Exp. Worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME No information			14. MOTHER'S MAIDEN NAME No Information		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-10-5975		17. INFORMANT Alexander Klukewicz, Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 260x DUE TO Conditions, if any, which gave rise to immediate cause (b) Diabetes (a), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R.C. Dodson			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 7/12/ 1958		
22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception			22d. LOCATION (City, town, or county) (State) Elkton, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home			24a. REC'D BY REGISTRAR DATE 1 4 '58		
			24b. REGISTRAR'S SIGNATURE A. L. Smith		

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7888 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07878

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Jesse Middle Lee Last Lynch		4. DATE OF DEATH Month 7 Day 4 Year 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26-1891
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY Clothing Store	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert O. Lynch		14. MOTHER'S MAIDEN NAME Ollie Rodgers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Jesse L. Lynch. Rising Sun. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF July 6, 1958	
22c. NAME OF CEMETERY OR CREMATORY West Nottingham		22d. LOCATION (City, town, or county) (State) Calover	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson		ADDRESS Rising Sun, Md.	
24a. REC'D BY REGISTRAR JUL 7 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Cecil Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARSHALL STATE DEPARTMENT OF HEALTH - BIRMINGHAM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE
DEPARTMENT OF HEALTH

County

City

State

Age

Sex

Color

Height

Weight

Build

Complexion

Birth

Death

Time

Place

Age

Sex

Color

Height

Weight

Birth

Death

Place

Birth

Death

Signature of Medical Examiner

Signature of Coroner

Signature of Registrar

County Coroner's Commission

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARSHALL STATE DEPARTMENT OF HEALTH ACT, CHAPTER 136, ACTS OF 1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025.

X

X

X

X

X

X

1-2-28

X

NOV. 2, 1928

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7890

CERTIFICATE OF DEATH

07879

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 932 Philadelphia Avenue	
3. NAME OF DECEASED (Type or print) George (NMI) Martin		4. DATE OF DEATH July 11 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-89
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker		9b. KIND OF BUSINESS OR INDUSTRY Shoemaking	
10a. BIRTHPLACE (State or foreign country) Armenia		10b. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. FATHER'S NAME Poe Martin		12. MOTHER'S MAIDEN NAME Unknown	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		14. SOCIAL SECURITY NO. Not ascertainable	
15. INFORMANT Address Hospital Records, VAH, Perry Point, Md.		16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Bronchopneumonia, bilateral, unresolved DUE TO Carcinoma of Lung with Metastasis to the hilar nodes, esophagus and vertebrae CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe. 491X INTERVAL BETWEEN ONSET AND DEATH 7 - 10 days Unknown	
17a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
18a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		18b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
18c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		18d. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-9-58, 19 to 7-11, 1958, and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Gruberger		DATE SIGNED 7-13-58	
PHYSICIAN'S NAME (Type) J. C. GRASBERGER, M.D.		ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/13/58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		DATE JUL 15 58	
Havre de Grace, Md.		24b. REGISTRAR'S SIGNATURE	

STATE OF MINNESOTA
DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
TO BE FILLED BY THE REGISTRAR
OF THE COUNTY IN WHICH THE DECEASED RESIDED
AT THE TIME OF DEATH

CERTIFICATE OF DEATH

1933

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John A. Doe		Male		45		Jan 15, 1933		St. Paul, Minn.	
Usual Residence		Occupation		Cause of Death		Manner of Death		Medical Attendant	
St. Paul, Minn.		Clerk		Heart Disease		Natural		Dr. J. B. Smith	
Date of Birth		Place of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Burial	
Jan 1, 1888		St. Paul, Minn.		Jan 10, 1933		Jan 12, 1933		Jan 15, 1933	
Date of Death		Place of Death		Cause of Death		Manner of Death		Medical Attendant	
Jan 15, 1933		St. Paul, Minn.		Heart Disease		Natural		Dr. J. B. Smith	
Usual Residence		Occupation		Cause of Death		Manner of Death		Medical Attendant	
St. Paul, Minn.		Clerk		Heart Disease		Natural		Dr. J. B. Smith	
Date of Birth		Place of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Burial	
Jan 1, 1888		St. Paul, Minn.		Jan 10, 1933		Jan 12, 1933		Jan 15, 1933	

7891

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City			c. LENGTH OF STAY IN 1b 45 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Cecil Martin Sr.				4. DATE OF DEATH Month July Day 28 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1903		9. AGE (In years lost birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Martin				14. MOTHER'S MAIDEN NAME Theresa Zajac			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Mary K. Martin		Address Chesapeake City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992 STARVATION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) OBSTRUCTION OF BOWEL DUE TO (c) CARCINOMA OF PANCREAS AND STOMACH						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS ONE YEAR 2 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 10, 1958, to July 28, 1958, that I last saw the deceased alive on July 28, 1958, and that death occurred at 11:35 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry V. Davis				ADDRESS (Street, city or town, state) CHESAPEAKE CITY MD		DATE SIGNED 7/30/58	
PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/2/1958		22c. NAME OF CEMETERY OR CREMATORY St. Roses Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home				ADDRESS Donald M. R. Elkton, Md.		24a. REC'D BY REGISTRAR DATE AUG 1 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED JOHN J. WYLAND</p>		<p>2. SEX Male</p>		<p>3. AGE 68</p>	
<p>4. RACE White</p>		<p>5. BIRTH DATE 1900</p>		<p>6. BIRTH PLACE Baltimore, Md.</p>	
<p>7. DECEASED DATE 1968</p>		<p>8. DECEASED TIME 10:00 AM</p>		<p>9. DECEASED PLACE Home</p>	
<p>10. DECEASED CAUSE Heart Disease</p>		<p>11. DECEASED DISEASE Coronary Artery Disease</p>		<p>12. DECEASED SYMPTOMS Chest pain, shortness of breath</p>	
<p>13. DECEASED MEDICAL HISTORY Hypertension, Diabetes</p>		<p>14. DECEASED MEDICATION Aspirin, Nitroglycerin</p>		<p>15. DECEASED SURVIVAL 10 years</p>	
<p>16. DECEASED OCCUPATION Teacher</p>		<p>17. DECEASED EDUCATION High School</p>		<p>18. DECEASED MARRIAGE Married</p>	
<p>19. DECEASED RELIGION Catholic</p>		<p>20. DECEASED ETHNICITY American</p>		<p>21. DECEASED NATIONALITY American</p>	
<p>22. DECEASED RESIDENCE 1234 Main St, Baltimore, Md.</p>		<p>23. DECEASED DEATH CERTIFICATE Yes</p>		<p>24. DECEASED BURIAL Yes</p>	
<p>25. DECEASED CREMATION No</p>		<p>26. DECEASED ORGAN DONOR No</p>		<p>27. DECEASED TISSUE DONOR No</p>	
<p>28. DECEASED CORNERSTONE No</p>		<p>29. DECEASED BURIAL PERMIT Yes</p>		<p>30. DECEASED CREMATION PERMIT No</p>	
<p>31. DECEASED BURIAL PLACE St. Mary's Cemetery</p>		<p>32. DECEASED CREMATION PLACE None</p>		<p>33. DECEASED BURIAL DATE 1968</p>	
<p>34. DECEASED CREMATION DATE None</p>		<p>35. DECEASED BURIAL TIME 11:00 AM</p>		<p>36. DECEASED CREMATION TIME None</p>	
<p>37. DECEASED BURIAL PLACE St. Mary's Cemetery</p>		<p>38. DECEASED CREMATION PLACE None</p>		<p>39. DECEASED BURIAL DATE 1968</p>	
<p>40. DECEASED CREMATION DATE None</p>		<p>41. DECEASED BURIAL TIME 11:00 AM</p>		<p>42. DECEASED CREMATION TIME None</p>	
<p>43. DECEASED BURIAL PLACE St. Mary's Cemetery</p>		<p>44. DECEASED CREMATION PLACE None</p>		<p>45. DECEASED BURIAL DATE 1968</p>	
<p>46. DECEASED CREMATION DATE None</p>		<p>47. DECEASED BURIAL TIME 11:00 AM</p>		<p>48. DECEASED CREMATION TIME None</p>	
<p>49. DECEASED BURIAL PLACE St. Mary's Cemetery</p>		<p>50. DECEASED CREMATION PLACE None</p>		<p>51. DECEASED BURIAL DATE 1968</p>	
<p>52. DECEASED CREMATION DATE None</p>		<p>53. DECEASED BURIAL TIME 11:00 AM</p>		<p>54. DECEASED CREMATION TIME None</p>	
<p>55. DECEASED BURIAL PLACE St. Mary's Cemetery</p>		<p>56. DECEASED CREMATION PLACE None</p>		<p>57. DECEASED BURIAL DATE 1968</p>	
<p>58. DECEASED CREMATION DATE None</p>		<p>59. DECEASED BURIAL TIME 11:00 AM</p>		<p>60. DECEASED CREMATION TIME None</p>	
<p>61. DECEASED BURIAL PLACE St. Mary's Cemetery</p>		<p>62. DECEASED CREMATION PLACE None</p>		<p>63. DECEASED BURIAL DATE 1968</p>	
<p>64. DECEASED CREMATION DATE None</p>		<p>65. DECEASED BURIAL TIME 11:00 AM</p>		<p>66. DECEASED CREMATION TIME None</p>	
<p>67. DECEASED BURIAL PLACE St. Mary's Cemetery</p>		<p>68. DECEASED CREMATION PLACE None</p>		<p>69. DECEASED BURIAL DATE 1968</p>	
<p>70. DECEASED CREMATION DATE None</p>		<p>71. DECEASED BURIAL TIME 11:00 AM</p>		<p>72. DECEASED CREMATION TIME None</p>	
<p>73. DECEASED BURIAL PLACE St. Mary's Cemetery</p>		<p>74. DECEASED CREMATION PLACE None</p>		<p>75. DECEASED BURIAL DATE 1968</p>	
<p>76. DECEASED CREMATION DATE None</p>		<p>77. DECEASED BURIAL TIME 11:00 AM</p>		<p>78. DECEASED CREMATION TIME None</p>	
<p>79. DECEASED BURIAL PLACE St. Mary's Cemetery</p>		<p>80. DECEASED CREMATION PLACE None</p>		<p>81. DECEASED BURIAL DATE 1968</p>	
<p>82. DECEASED CREMATION DATE None</p>		<p>83. DECEASED BURIAL TIME 11:00 AM</p>		<p>84. DECEASED CREMATION TIME None</p>	
<p>85. DECEASED BURIAL PLACE St. Mary's Cemetery</p>		<p>86. DECEASED CREMATION PLACE None</p>		<p>87. DECEASED BURIAL DATE 1968</p>	
<p>88. DECEASED CREMATION DATE None</p>		<p>89. DECEASED BURIAL TIME 11:00 AM</p>		<p>90. DECEASED CREMATION TIME None</p>	
<p>91. DECEASED BURIAL PLACE St. Mary's Cemetery</p>		<p>92. DECEASED CREMATION PLACE None</p>		<p>93. DECEASED BURIAL DATE 1968</p>	
<p>94. DECEASED CREMATION DATE None</p>		<p>95. DECEASED BURIAL TIME 11:00 AM</p>		<p>96. DECEASED CREMATION TIME None</p>	
<p>97. DECEASED BURIAL PLACE St. Mary's Cemetery</p>		<p>98. DECEASED CREMATION PLACE None</p>		<p>99. DECEASED BURIAL DATE 1968</p>	
<p>100. DECEASED CREMATION DATE None</p>		<p>101. DECEASED BURIAL TIME 11:00 AM</p>		<p>102. DECEASED CREMATION TIME None</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07881

7892

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b visitor	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Rydol 75 x 3		d. STREET ADDRESS 1438 Scrope Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Kent Mathias		4. DATE OF DEATH Month Day Year 7 7 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7 1955
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months Day Hours Min. 7 1	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Philadelphia Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Valentine Mathias		14. MOTHER'S MAIDEN NAME Ethel Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Paul V. Mathias, Rydol. Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell into the Chesapeake Canal Chesapeake City	
20c. TIME OF INJURY Month Day Year Hour Min. Sec. 7 7 19 58		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Canal Chesapeake Cecil Md		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-8-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/9/ 1958	
22c. NAME OF CEMETERY OR CREMATORY Pippin Funeral Home		22d. LOCATION (City, town, or county) (State) Philadelphia, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Donald M. Lee		24a. REC'D JUL 14 '58	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE W. Leach	

STATE OF MARYLAND
HEALTH DEPARTMENT

1

7882

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		DATE OF DEATH JAN 12 1912	
PLACE OF DEATH HOME		CITY BALTIMORE	
AGE 65		SEX MALE	
OCCUPATION CLOCK MAKER		EDUCATION HIGH SCHOOL	
MARRIED YES		SINGLE NO	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
DISEASES PREEXISTING HYPERTENSION		DISEASES OCCURRING CORONARY THROMBOSIS	
SIGNS AND SYMPTOMS PAIN IN CHEST		TREATMENT NONE	
FINDINGS AT AUTOPSY CORONARY ARTERY DISEASE		FINDINGS AT EXAMINATION HEALTHY	
SIGNATURE OF EXAMINER J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS	
DATE JAN 12 1912		PLACE BALTIMORE	

7893

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Del</u> b. COUNTY <u>Mi. C 46X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bear Del</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Morgan-Hurling Home</u>		d. STREET ADDRESS <u>Chesapeake City Md</u>	
3. NAME OF DECEASED (Type or print) <u>Bertie</u> First <u>L</u> Middle <u>McCoys</u> Last		4. DATE OF DEATH <u>July 4</u> Month <u>4</u> Day <u>1958</u> Year	
5. SEX <u>Fi</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7-1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Perma</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George F. Runner</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. Richardson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>L</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>L</u>	
17. INFORMANT <u>Eva M. Nesbitt Nottingham Pa</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SENILITY</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROSIS</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>64 MONTHS</u> YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 24</u> , 19 <u>58</u> , to <u>July 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>58</u> , and that death occurred at <u>2:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7145</u> DATE SIGNED <u>7/5/58</u>			
ACTUAL SIGNATURE <u>Henry V. Davis MD</u> M.D.			
PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS MD</u>		<u>CHESAPEAKE CITY MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 9-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Springs L.C.O.A. Lancaster Co Pa</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Jones</u> ADDRESS <u>Mulwah Del</u>		24a. REC'D BY REGISTRAR <u>Jul 9 58</u>	24b. REGISTRAR'S SIGNATURE <u>Q. L. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7864 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07883

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mass. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 8 Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Bedford 58x-3 ✓	
3. NAME OF DECEASED (Type or print) First Middle Last Ella H. Midgley		4. DATE OF DEATH Month 7 Day 13 Year 19 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-1883
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY House Keeping	
11. BIRTHPLACE (State or foreign country) Providence, R.I.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hayward		14. MOTHER'S MAIDEN NAME Hanna Harper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --- -- -- -- -- -- -- --	
17. INFORMANT Wm. H. Midgley, 16 Hussey St, Mass.		Address New Bedford,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Renal Failure, Anuria Arteriosclerotic DUE TO (b) cardiovascular-renal disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-13-58	
EXAMINER'S NAME (Type) R.C. Dodson		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-13-58	
22c. NAME OF CEMETERY OR CREMATORY Acushnet Cemetery		22d. LOCATION (City, town, or county) (State) Acushnet, Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		ADDRESS 101 N. 2nd St. Elkton, Md.	
24a. REC'D BY REGISTRAR DATE JUL 15 '58		24b. REGISTRAR'S SIGNATURE	

M

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15, 1900		New York, N.Y.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Hospital	
Date of Death		Time of Death		Hour		Minute		Place of Death	
Jan 20, 1945		10:30 AM		10		30		Hospital	
Physician		Medical Examiner		Nurse		Burial		Cremation	
Dr. J. Smith		Dr. J. Smith		Mrs. J. Smith		Buried		Cremated	
Signature of Physician		Signature of Medical Examiner		Signature of Nurse		Signature of Burial		Signature of Cremation	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Time of Certificate		Hour		Minute		Place of Certificate	
Jan 21, 1945		11:00 AM		11		00		Hospital	

Arkansas State Department of Health
Bureau of Vital Statistics
Little Rock, Arkansas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07885

7895

CERTIFICATE OF DEATH

Reg. Dist.

17885

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 1 month 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2619 - 11th Street, N.W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GEORGE Middle W. Last MILES				4. DATE OF DEATH Month July Day 23 Year 1958			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 20, 1893	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM MILES				14. MOTHER'S MAIDEN NAME ANNIE COLYER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Address Hospital Records, VA Hospital, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pylonephritis bilateral 605x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Cystitis urinary bladder, severe DUE TO (c) Cerebral edema, moderately severe PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral edema, moderately severe							INTERVAL BETWEEN ONSET AND DEATH 4-5 days 8-10 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 12 , 19 58 , to July 23 , 19 58 , and that death occurred at 5:09 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 7-23-58							
ACTUAL SIGNATURE W. M. HARRIS M.D.				PHYSICIAN'S NAME (Type) W. M. HARRIS Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-23-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md. ADDRESS Havre de Grace, Md.				24a. REC'D BY REGISTRAR JUL 25 58 DATE		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of Maryland

County of Prince George's

1919 - 1920

1920 - 1921

1921 - 1922

1922 - 1923

1923 - 1924

1924 - 1925

1925 - 1926

1926 - 1927

1927 - 1928

1928 - 1929

1929 - 1930

1930 - 1931

1931 - 1932

1932 - 1933

1933 - 1934

1934 - 1935

1935 - 1936

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07886

7865

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film 0232 8-5-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William L. Packer</u>		4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-1873</u>
9. AGE (in years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William L. Packer</u>		14. MOTHER'S MAIDEN NAME <u>Anne A. McBride</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Hospital Records, Elkton, Md.</u>		18. INTERVAL BETWEEN ONSET AND DEATH	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia following Fractured Right femur</u> 983X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was fighting with another patient and was knocked down</u>	
20c. TIME OF INJURY Month, Day, Year <u>8</u> a. m. <u>5-17-58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing home</u>		20f. (City or town) (County) (State) <u>Calvert Cecil Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R.C. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. NAME OF BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Buried</u>		22b. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>	
22c. LOCATION (City, town, or county) (State) <u>Zion, Cecil Co, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24. REC'D BY REGISTRAR DATE <u>JUL 14 '58</u>	
25. REGISTRAR'S SIGNATURE <u>Ralph E. Hicks</u>		26. REGISTRAR'S SIGNATURE <u>Ralph E. Hicks</u>	

FOR STATE
HEALTH DEPT.



MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX	
DATE OF DEATH		PLACE OF DEATH		CITY	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
EDUCATION		RELIGION		RACE	
MARITAL STATUS		PREVIOUS ILLNESS		TREATMENT	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
OCCUPATION AT BIRTH		CAUSE OF BIRTH		MANNER OF BIRTH	
EDUCATION AT BIRTH		RELIGION AT BIRTH		RACE AT BIRTH	
MARITAL STATUS AT BIRTH		PREVIOUS ILLNESS AT BIRTH		TREATMENT AT BIRTH	
DATE OF DEATH		PLACE OF DEATH		CITY	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
EDUCATION		RELIGION		RACE	
MARITAL STATUS		PREVIOUS ILLNESS		TREATMENT	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
OCCUPATION AT BIRTH		CAUSE OF BIRTH		MANNER OF BIRTH	
EDUCATION AT BIRTH		RELIGION AT BIRTH		RACE AT BIRTH	
MARITAL STATUS AT BIRTH		PREVIOUS ILLNESS AT BIRTH		TREATMENT AT BIRTH	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

7896

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07887

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick	
c. LENGTH OF STAY IN 1b visiting		d. STREET ADDRESS Warwick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake & Delaware Canal		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rayburn Bishop Perkins		4. DATE OF DEATH Month Day Year 7 17 1958	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-1941
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Rayburn Perkins		14. MOTHER'S MAIDEN NAME Mary Adelaide Dyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Perkins, Warwick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Went into deep a water		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 2:25 p. m. 7 17 19 58		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ches. Del Canal		20f. (City or town) (County) (State) Chesapeake City Cecil Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-18-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/58	
22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cem.		22d. LOCATION (City, town, or county) (State) Bohemia Manor, M d.	
23. FUNERAL DIRECTOR'S SIGNATURE Edw. R. Bell		ADDRESS Wilm. Del.	
24a. REC'D BY REGISTRAR JUL 21 '58		24b. REGISTRAR'S SIGNATURE Al. Beach	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9-2-56

Case #

Residence

Age

Occupation

Marital Status

Cause of Death

Immediate Cause of Death

17

7

Married

Married

Married

18

11-30-1911

0

11

U.S.A.

Elmer, M.

Married

Married

Married

Married, Baltimore, Md.

10

Married

x

Hand into deep water

x

Case #

1

x

7 17 30

2-2-56

x

x

x

7-18-56

x

2-10-56

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7866 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07888

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 30 minutes X Chesapeake City R.D.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Raymond Bishop Perkins		4. DATE OF DEATH Month 7 Day 4 Year 19 58	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM F Perkins		14. MOTHER'S MAIDEN NAME Emma Hood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT Mary Perkins, Chesapeake City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 981X Hemorrhage from Gun shot wound of DUE TO (b) left thigh anterior surface Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot with shot gun	
20c. TIME OF INJURY Month, Day, Year Hour 7 4 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Town		20f. (City or town) Warwick (County) Cecil (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-5-58	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/10/58	
22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cem.		22d. LOCATION (City, town, or county) Bohemia Manor, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edmund R. Bell		ADDRESS Wilm. Del.	
24a. REC'D BY REGISTRAR DATE JUL 8 '58		24b. REGISTRAR'S SIGNATURE	

NEW STATE
HEALTH DEPT

11

11



THE STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
BOSTON, MASSACHUSETTS

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
1966 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, First, Middle Initial) <i>John Doe</i>	
2. DATE OF DEATH <i>10-15-66</i>	
3. TIME OF DEATH <i>10:00 AM</i>	
4. PLACE OF DEATH <i>Home</i>	
5. DECEASED'S AGE (Years, Months, Days) <i>65-10-15</i>	
6. SEX <i>Male</i>	
7. RACE <i>White</i>	
8. DECEASED'S BIRTH DATE <i>10-15-01</i>	
9. DECEASED'S BIRTH PLACE <i>Baltimore, Md.</i>	
10. DECEASED'S US CITIZENSHIP <i>Yes</i>	
11. DECEASED'S MARITAL STATUS <i>Married</i>	
12. DECEASED'S OCCUPATION <i>Teacher</i>	
13. DECEASED'S EDUCATION <i>High School Graduate</i>	
14. DECEASED'S RELIGION <i>Catholic</i>	
15. DECEASED'S SOCIAL SECURITY NUMBER <i>123-45-6789</i>	
16. DECEASED'S MOTHER'S MARRIAGE LICENSE NUMBER <i>123456789</i>	
17. DECEASED'S MARRIAGE LICENSE NUMBER <i>123456789</i>	
18. DECEASED'S DEED OF MORTGAGE NUMBER <i>123456789</i>	
19. DECEASED'S DEED OF MORTGAGE NUMBER <i>123456789</i>	
20. DECEASED'S DEED OF MORTGAGE NUMBER <i>123456789</i>	
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100. DECEASED'S DEED OF MORTGAGE NUMBER <i>123456789</i>	

7-2-56

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07889

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 48 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick, Rural	
3. NAME OF DECEASED (Type or print) John Hazel Price		4. DATE OF DEATH 7 2 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME J. Rodney Price		14. MOTHER'S MAIDEN NAME Jennie Gunkel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. J. Hazel Price, Warwick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chrusched chest and shock 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) seperation of ribs from sternum (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto hit tree	
20c. TIME OF INJURY Month, Day, Year Hour 8 a.m. 6-30-58		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) Warwick (County) Cecil (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-4-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-6-58	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cem.		22d. LOCATION (City, town, or county) Chesapeake City Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. L. Daniel		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
Middletown, Del.		DATE JUL 7 '58	

STATE OF
NEW YORK

IN SENATE
JANUARY 1, 1901

REPORT OF THE
COMMISSIONER OF THE
DEPARTMENT OF HEALTH

FOR THE YEAR
1900

ALBANY:

AND
SUNNYVALE:

THE
UNIVERSITY OF THE STATE OF NEW YORK

PRINTED BY THE
UNIVERSITY OF THE STATE OF NEW YORK

1901

ALBANY:

AND
SUNNYVALE:

THE
UNIVERSITY OF THE STATE OF NEW YORK

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1901

ALBANY:

AND
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UNIVERSITY OF THE STATE OF NEW YORK

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UNIVERSITY OF THE STATE OF NEW YORK

1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7868 CERTIFICATE OF DEATH

Reg. Dist. No.

07890

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILEY ADOLPHUS REEVES</u>		4. DATE OF DEATH Month Day Year <u>JULY 11 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 17-1895</u>
9. AGE (In years lost birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Worker</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JONA REEVES</u>		14. MOTHER'S MAIDEN NAME <u>MELINDA HENDERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-2622</u>	
17. INFORMANT <u>HELEN PRICE (Daughter)</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PULMONARY INFARCTION</u> DUE TO (c) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 Minutes</u> <u>10 DAYS</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PARKINSONISM - BRIGHT DIS.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-5-1958</u> , to <u>7-11-1958</u> , that I lost the deceased alive on <u>7-11-58</u> , and that death occurred at <u>7:48 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Wallace Ave.</u> DATE SIGNED ACTUAL SIGNATURE <u>Luis M. Cuza</u> M.D. <u>Wallace Ave.</u> PHYSICIAN'S NAME (Type) <u>LUIS M. CUZA</u> <u>NORTH EAST, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Union, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home</u>		ADDRESS <u>Elkton, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Wallace Ave.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item #7-Film C232 - 8/1/58 - mb

7869

CERTIFICATE OF DEATH

07891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, Md</u>		c. LENGTH OF STAY IN 1b <u>28 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, Md</u>	
		d. STREET ADDRESS <u>1307 Elkton Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Travels</u> Last <u>Reynolds</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1958</u>
9. AGE (In years lost birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>19</u> Days <u>18</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Nottingham Pa</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harvey Graves</u>		14. MOTHER'S MAIDEN NAME <u>Saline Pierson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Thomas Reynolds</u>		Address <u>Elkton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> died <u>instantly</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 16</u> , 19 <u>58</u> , to <u>July 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 29</u> , 19 <u>58</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>233 E. Main Street</u> DATE SIGNED <u>7/23/58</u> ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u> <u>Elkton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosebank</u>		22d. LOCATION (City, town, or county) (State) <u>Cabaret Cecil Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 28 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Search</u>			

CERTIFICATE OF DEATH

1902

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1902

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07892

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS 100 Church St.	
3. NAME OF DECEASED (Type or print) Charles Rhoades		4. DATE OF DEATH 7 31 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-1883
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Lumber	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Rhoades		14. MOTHER'S MAIDEN NAME Annie E. Lusby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 222-01-8629	
17. INFORMANT Address Emily Caldwell, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150x Carcinoma of Esophagus with metasis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-3-58	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cem.		22d. LOCATION (City, town, or county) (State) Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Daniel B. Pippin ELKTON, MD		24a. REC'D BY REGISTRAR DATE AUG 5 '58	
		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH - BATHING BEACHES
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

1. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.
2. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.
3. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.
4. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.
5. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.
6. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.
7. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.
8. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.
9. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.
10. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers.
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 FilmG232 8-4-58 et

07893

7871

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EIKTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HACKS POINT, RURAL EARLEVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL		d. STREET ADDRESS 1	
3. NAME OF DECEASED First JOHN Middle E. Last ROBINSON		4. DATE OF DEATH Month JULY Day 25 Year 1958	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JULY 26, 1892
9. AGE (In years, last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL LABORER GENERAL		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN ROBINSON		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-09-4875	
17. INFORMANT Mrs. PAULINE PREWITT, OXFORD, PA.		Address RD #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute Anteroseptal Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 30 hr 1 yr 6 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-24 , 19 58 , to 7-25 , 19 58 , that I last saw the deceased alive on 7-25 , 19 58 , and that death occurred at 9:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 325 E Main St, Newark, Del DATE SIGNED 7-25-58			
ACTUAL SIGNATURE Williford Epps M.D.		22a. REC'D BY REGISTRAR JUL 29 '58	
PHYSICIAN'S NAME (Type) Edward Fellows, Millington, Md		24b. REGISTRAR'S SIGNATURE W. E. Epps	
22b. DATE THEREOF 7/27/58		22c. NAME OF CEMETERY OR CREMATORY GALENA CEM.	
22d. LOCATION (City, town, or county) (State) GALENA, KENT CO. MD.		23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md	

CERTIFICATE OF DEATH

<p>1. Name of deceased: John Robinson</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 1875</p>		<p>4. Place of birth: Massachusetts</p>	
<p>5. Date of death: 1915</p>		<p>6. Place of death: Massachusetts</p>	
<p>7. Cause of death: Heart Disease</p>		<p>8. Duration of illness: 10 days</p>	
<p>9. Name of physician: Dr. J. B. Smith</p>		<p>10. Name of undertaker: John Doe</p>	
<p>11. Name of funeral home: John Doe</p>		<p>12. Name of cemetery: Greenwood</p>	
<p>13. Name of burial place: Greenwood</p>		<p>14. Name of interment place: Greenwood</p>	
<p>15. Name of informant: John Doe</p>		<p>16. Name of informant: John Doe</p>	
<p>17. Name of informant: John Doe</p>		<p>18. Name of informant: John Doe</p>	
<p>19. Name of informant: John Doe</p>		<p>20. Name of informant: John Doe</p>	
<p>21. Name of informant: John Doe</p>		<p>22. Name of informant: John Doe</p>	
<p>23. Name of informant: John Doe</p>		<p>24. Name of informant: John Doe</p>	
<p>25. Name of informant: John Doe</p>		<p>26. Name of informant: John Doe</p>	
<p>27. Name of informant: John Doe</p>		<p>28. Name of informant: John Doe</p>	
<p>29. Name of informant: John Doe</p>		<p>30. Name of informant: John Doe</p>	
<p>31. Name of informant: John Doe</p>		<p>32. Name of informant: John Doe</p>	
<p>33. Name of informant: John Doe</p>		<p>34. Name of informant: John Doe</p>	
<p>35. Name of informant: John Doe</p>		<p>36. Name of informant: John Doe</p>	
<p>37. Name of informant: John Doe</p>		<p>38. Name of informant: John Doe</p>	
<p>39. Name of informant: John Doe</p>		<p>40. Name of informant: John Doe</p>	
<p>41. Name of informant: John Doe</p>		<p>42. Name of informant: John Doe</p>	
<p>43. Name of informant: John Doe</p>		<p>44. Name of informant: John Doe</p>	
<p>45. Name of informant: John Doe</p>		<p>46. Name of informant: John Doe</p>	
<p>47. Name of informant: John Doe</p>		<p>48. Name of informant: John Doe</p>	
<p>49. Name of informant: John Doe</p>		<p>50. Name of informant: John Doe</p>	
<p>51. Name of informant: John Doe</p>		<p>52. Name of informant: John Doe</p>	
<p>53. Name of informant: John Doe</p>		<p>54. Name of informant: John Doe</p>	
<p>55. Name of informant: John Doe</p>		<p>56. Name of informant: John Doe</p>	
<p>57. Name of informant: John Doe</p>		<p>58. Name of informant: John Doe</p>	
<p>59. Name of informant: John Doe</p>		<p>60. Name of informant: John Doe</p>	
<p>61. Name of informant: John Doe</p>		<p>62. Name of informant: John Doe</p>	
<p>63. Name of informant: John Doe</p>		<p>64. Name of informant: John Doe</p>	
<p>65. Name of informant: John Doe</p>		<p>66. Name of informant: John Doe</p>	
<p>67. Name of informant: John Doe</p>		<p>68. Name of informant: John Doe</p>	
<p>69. Name of informant: John Doe</p>		<p>70. Name of informant: John Doe</p>	
<p>71. Name of informant: John Doe</p>		<p>72. Name of informant: John Doe</p>	
<p>73. Name of informant: John Doe</p>		<p>74. Name of informant: John Doe</p>	
<p>75. Name of informant: John Doe</p>		<p>76. Name of informant: John Doe</p>	
<p>77. Name of informant: John Doe</p>		<p>78. Name of informant: John Doe</p>	
<p>79. Name of informant: John Doe</p>		<p>80. Name of informant: John Doe</p>	
<p>81. Name of informant: John Doe</p>		<p>82. Name of informant: John Doe</p>	
<p>83. Name of informant: John Doe</p>		<p>84. Name of informant: John Doe</p>	
<p>85. Name of informant: John Doe</p>		<p>86. Name of informant: John Doe</p>	
<p>87. Name of informant: John Doe</p>		<p>88. Name of informant: John Doe</p>	
<p>89. Name of informant: John Doe</p>		<p>90. Name of informant: John Doe</p>	
<p>91. Name of informant: John Doe</p>		<p>92. Name of informant: John Doe</p>	
<p>93. Name of informant: John Doe</p>		<p>94. Name of informant: John Doe</p>	
<p>95. Name of informant: John Doe</p>		<p>96. Name of informant: John Doe</p>	
<p>97. Name of informant: John Doe</p>		<p>98. Name of informant: John Doe</p>	
<p>99. Name of informant: John Doe</p>		<p>100. Name of informant: John Doe</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

07894

7897

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. LENGTH OF STAY IN 1b <u>28 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>J.</u> Last <u>SALIK</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 1, 1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital Fire Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John J. Salik</u>		14. MOTHER'S MAIDEN NAME <u>Kate Renner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-I</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records, VA Hospital, Perry Point, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis, Diffuse</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Extravasated contents of viscera</u> DUE TO (c) <u>Post-operative obstruction of the large bowel</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u> <u>4-5 days</u> <u>4-5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 9, 1958, to July 7, 1958</u> , and that death occurred at <u>1:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. M. Harris</u>		DATE SIGNED <u>7-7-58</u>	
PHYSICIAN'S NAME (Type) <u>W. M. HARRIS</u>		ADDRESS (Street, city or town, state) <u>V.A. Hospital, Perry Point, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-10-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Run</u>		22d. LOCATION (City, town, or county) (State) <u>Harford County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Hayre DeGrace, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. A. Leach</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07895
96

7898

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City 13X-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 165 Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle M. STONESIFER Last		4. DATE OF DEATH Month July Day 13 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-23-11
9. AGE (In years last birthday) yrs. 47		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Not ascertainable	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oliver Stonesifer		14. MOTHER'S MAIDEN NAME Annie Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. Not ascertainable	
17. INFORMANT Hospital Records, VA Hosp., Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, rt. lower lobe, unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema, bilateral, moderate severe DUE TO (c) Arteriosclerotic heart disease.		INTERVAL BETWEEN ONSET AND DEATH 4 - 5 days Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, moderate. 491X		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-20 , 19 53 , to 7-13 , 19 58 , and that death occurred on 19 58 , and that death occurred on 10:45 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Graser		ADDRESS (Street, city or town, state) M.D. VA Hospital, Perry Point, Maryland	
DATE SIGNED 7-13-58			
PHYSICIAN'S NAME (Type) J.C. GRASBERGER, M.D., Acting Director, Professional Services.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-26-58	
22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higginbotham		ADDRESS Ellicott City, Md.	
24a. REC'D BY REGISTRAR JUL 15 '58		24b. REGISTRAR'S SIGNATURE W. H. Leach	

MEDICAL CERTIFICATION

2

50

I

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician	
11. Signature of Registrar		12. Signature of Coroner		13. Signature of Medical Examiner		14. Signature of Funeral Home		15. Signature of Burial Place	
16. Signature of Health Officer		17. Signature of County Health Officer		18. Signature of City Health Officer		19. Signature of District Health Officer		20. Signature of State Health Officer	
21. Signature of State Health Officer		22. Signature of State Health Officer		23. Signature of State Health Officer		24. Signature of State Health Officer		25. Signature of State Health Officer	
26. Signature of State Health Officer		27. Signature of State Health Officer		28. Signature of State Health Officer		29. Signature of State Health Officer		30. Signature of State Health Officer	
31. Signature of State Health Officer		32. Signature of State Health Officer		33. Signature of State Health Officer		34. Signature of State Health Officer		35. Signature of State Health Officer	
36. Signature of State Health Officer		37. Signature of State Health Officer		38. Signature of State Health Officer		39. Signature of State Health Officer		40. Signature of State Health Officer	
41. Signature of State Health Officer		42. Signature of State Health Officer		43. Signature of State Health Officer		44. Signature of State Health Officer		45. Signature of State Health Officer	
46. Signature of State Health Officer		47. Signature of State Health Officer		48. Signature of State Health Officer		49. Signature of State Health Officer		50. Signature of State Health Officer	
51. Signature of State Health Officer		52. Signature of State Health Officer		53. Signature of State Health Officer		54. Signature of State Health Officer		55. Signature of State Health Officer	
56. Signature of State Health Officer		57. Signature of State Health Officer		58. Signature of State Health Officer		59. Signature of State Health Officer		60. Signature of State Health Officer	
61. Signature of State Health Officer		62. Signature of State Health Officer		63. Signature of State Health Officer		64. Signature of State Health Officer		65. Signature of State Health Officer	
66. Signature of State Health Officer		67. Signature of State Health Officer		68. Signature of State Health Officer		69. Signature of State Health Officer		70. Signature of State Health Officer	
71. Signature of State Health Officer		72. Signature of State Health Officer		73. Signature of State Health Officer		74. Signature of State Health Officer		75. Signature of State Health Officer	
76. Signature of State Health Officer		77. Signature of State Health Officer		78. Signature of State Health Officer		79. Signature of State Health Officer		80. Signature of State Health Officer	
81. Signature of State Health Officer		82. Signature of State Health Officer		83. Signature of State Health Officer		84. Signature of State Health Officer		85. Signature of State Health Officer	
86. Signature of State Health Officer		87. Signature of State Health Officer		88. Signature of State Health Officer		89. Signature of State Health Officer		90. Signature of State Health Officer	
91. Signature of State Health Officer		92. Signature of State Health Officer		93. Signature of State Health Officer		94. Signature of State Health Officer		95. Signature of State Health Officer	
96. Signature of State Health Officer		97. Signature of State Health Officer		98. Signature of State Health Officer		99. Signature of State Health Officer		100. Signature of State Health Officer	

7899

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b visiting	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake & Delaware Canal		d. STREET ADDRESS Warwick	
3. NAME OF DECEASED (Type or print) Bessie Ann Turner		4. DATE OF DEATH Month 7 Day 17 Year 1958	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-12
9. AGE (In years last birthday) 16 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Preston Turner		14. MOTHER'S MAIDEN NAME Elsie Viola Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Harry Preston Turner, Warwick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) went into too deep of water in canal			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 2.25 7 17 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake & Del Canal		20f. (City or town) (County) (State) Chesapeake City Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-18-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/21/58	22c. NAME OF CEMETERY OR CREMATORY Cecilton Cem.	22d. LOCATION (City, town, or county) (State) Cecilton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Chas. R. Bell		ADDRESS Wilm. Del.	
24a. REC'D BY REGISTRAR DATE JUL 21 '58		24b. REGISTRAR'S SIGNATURE R.C. Dodson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Color

Death

Residence

Occupation

Place of death

Cause of death

Manner of death

Signature

10

17

7

18

1-1-12

X

Age

Sex

0

1

School

Statement

Witness, M.D.

U.S.A.

Miss Viola Davis

Harry Preston Turner

Harry Preston Turner, Witness, M.D.

no

Crowned

X

X

Went into the room of water in canal

Diagnosis: Chyl. Canal

X Chyl. Canal

17 18

2.2

X

X

X

X

7-11-10

X

1.10.10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7900 CERTIFICATE OF DEATH

07897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charlie V. Tyler		4. DATE OF DEATH July 5 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-6-92
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Animal caretaker		10b. KIND OF BUSINESS OR INDUSTRY Walter Reed Army Hosp. Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anderson Tyler		14. MOTHER'S MAIDEN NAME Ella Wells	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 578 32 5612	
17. INFORMANT Address Hospital Records, VA Hospital, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Bronchopneumonia, left lower lobe unresolved DUE TO (b) Abdominal carcinomatous DUE TO (c) Adenocarcinoma of stomach INTERVAL BETWEEN ONSET AND DEATH 4-5 days Unknown Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15 19 58, to July 5 19 58, that he last saw the deceased alive on 7-5-58, and that death occurred at 8:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. M. Harris M.D.		ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md. DATE SIGNED 7-5-58	
PHYSICIAN'S NAME (Type) W. M. HARRIS, M.D. Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/10/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Fort Meyers, Virginia	
23. SIGNATURE OF REGISTRAR A. T. Stewart		ADDRESS 30 H. Street N.E. Wash., D.C.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE JUL 8 '58			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers.
The registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07898

7872 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Ruby Williamson		4. DATE OF DEATH Month July Day 27 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert O. Williamson		14. MOTHER'S MAIDEN NAME Helen Rucker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert O. Williamson, Charlestown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory obstruction. 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 24, 1958, to July 27, 1958, that I last saw the deceased alive on July 27, 1958, and that death occurred at 8:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Glenn M. M. D.		ADDRESS (Street, city or town, state) Cecil Md.	
PHYSICIAN'S NAME (Type) Glenn M. M. D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/58	
22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery		22d. LOCATION (City, town, or county) Cecil Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR DATE JUL 31 '58		24b. REGISTRAR'S SIGNATURE	

20653310XV5

CERTIFICATE OF DEATH

NAME OF DECEASED Robert E. Williamson		SEX Male		AGE 68	
DATE OF DEATH June 23, 1968		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		PLACE OF BIRTH Baltimore, Maryland	
OCCUPATION Retired		EDUCATION High School Graduate		MARITAL STATUS Married	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF NOTARY (None)	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07899

7901

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Cecil STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North East LENGTH OF STAY (in this place) 65 yrs				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Cecil CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North East STREET ADDRESS (If rural give location) Cecil Ave			
3. NAME OF DECEASED (Type or Print) (First) Susie (Middle) Yeamans (Last) Yeamans				4. DATE OF DEATH (Month) 7 (Day) 13 (Year) 58			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Widowed	8. DATE OF BIRTH Oct. 16, 1871	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months 7 Days 13		IF UNDER 24 HRS. Hours 58 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joel R. Ryan				14. MOTHER'S MAIDEN NAME Eliza Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs Viola Devine, North East, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 450.0 IMMEDIATE CAUSE (A) Generalized Arteriosclerosis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) STATING UNDERLYING CAUSE LAST. DUE TO (C)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1 June, 1958 , to 13 July, 1958 , that I last saw the deceased alive on 12 July, 1958 , and that death occurred at 6:30 A.M. from the causes end on the date stated above. SIGNATURE Klaus H. Thiel M.D. North East, Md DATE SIGNED 14 July '58							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-16-1958		NAME OF CEMETERY OR CREMATORY North East Methodist		LOCATION (City, town, or county) (State) North East, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE W. L. Smith		25. FUNERAL DIRECTOR'S SIGNATURE W. L. Smith		ADDRESS Perryville, Md.	
DATE JUL 16 '58							

CERTIFICATE OF DEATH

1901

Reg. Code No.

1. NAME OF DECEASED Cecil		2. SEX Male		3. AGE 35 yrs		4. OCCUPATION Cecil Ave.	
5. PLACE OF BIRTH Cecil Ave.		6. PLACE OF DEATH Cecil Ave.		7. DATE OF DEATH Oct. 12, 1901		8. TIME OF DEATH 10:30 AM	
9. CAUSE OF DEATH Typhoid		10. MEDICAL CERTIFICATE The above named person died of Typhoid		11. SIGNATURE OF PHYSICIAN J. H. Taylor		12. SIGNATURE OF REGISTRAR J. H. Taylor	
13. NAME OF NEXT OF KIN Mrs. J. H. Taylor		14. ADDRESS Cecil Ave.		15. CITY Cecil		16. COUNTY Cecil	
17. STATE West Virginia		18. ZIP CODE 26001		19. DATE OF BIRTH Oct. 12, 1901		20. TIME OF BIRTH 10:30 AM	
21. NAME OF DECEASED Cecil		22. SEX Male		23. AGE 35 yrs		24. OCCUPATION Cecil Ave.	
25. PLACE OF BIRTH Cecil Ave.		26. PLACE OF DEATH Cecil Ave.		27. DATE OF DEATH Oct. 12, 1901		28. TIME OF DEATH 10:30 AM	
29. CAUSE OF DEATH Typhoid		30. MEDICAL CERTIFICATE The above named person died of Typhoid		31. SIGNATURE OF PHYSICIAN J. H. Taylor		32. SIGNATURE OF REGISTRAR J. H. Taylor	
33. NAME OF NEXT OF KIN Mrs. J. H. Taylor		34. ADDRESS Cecil Ave.		35. CITY Cecil		36. COUNTY Cecil	
37. STATE West Virginia		38. ZIP CODE 26001		39. DATE OF BIRTH Oct. 12, 1901		40. TIME OF BIRTH 10:30 AM	

26001